Elizabeth Margaret Godson
EFT International Certified Practitioner

Client Medical and Release Form

Client Name: _____

Address: _____

City: _____ Prov/State: _____ Postal/Zip Code: _____

Country: _____ Work Ph: _____ Home Ph: _____

Cell: _____ Email: _____

Age: _____ Present Occupation: _____

Who may I thank for referring you to me? _____

Are you using any other therapies at this time for your health? Yes ___ No ___
If yes, please describe:

_____

_____

_____

Are you presently under the care of a chiropractor? Yes ___ No ___
Have you ever had craniosacral therapy? Yes ___ No ___
Are you presently under the care of a naturopath? Yes ___ No ___

Please list any problem(s) that you would like to address and how long they have been present. Feel free to use the back of this page if necessary.

_____

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Please list any prescription drugs you are presently taking and which health challenge they are currently addressing.

Have you had any surgery? Yes ___ No ___
If yes, please describe below (include any dental surgery):

Surgery	Date

If you have had any lab tests, x-rays or other diagnostic tests done in the past year, please list them below with details:

Have you ever had a bad fall, been in a car accident or had any other serious accident: Yes ___ No ___

If yes, please describe and provide date(s) of the injury:

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Are you diabetic?	Yes ___	No ___
Do you have problems sleeping?	Yes ___	No ___
Do you have high blood pressure?	Yes ___	No ___
Have you ever had heart problems?	Yes ___	No ___
Have allergy symptoms been a problem?	Yes ___	No ___
Have you been bothered by skin rashes, itching or hives?	Yes ___	No ___
Do you get short of breath easily?	Yes ___	No ___
Have you had problems with asthma?	Yes ___	No ___
Do you have digestive problems?	Yes ___	No ___
Have you ever lost consciousness?	Yes ___	No ___
Do you have problems with numbness?	Yes ___	No ___
Do you have problems with joint pain?	Yes ___	No ___
Have you ever had a seizure?	Yes ___	No ___
Is there a history of seizures in your family?	Yes ___	No ___
Do you suffer from anxiety?	Yes ___	No ___
Do you suffer from panic attacks?	Yes ___	No ___
Do you or have you ever suffered from depression?	Yes ___	No ___

Have you ever received a psychiatric diagnosis? Yes ___ No ___
If yes, please provide details:

_____

_____

_____

Is there anything else you would like to tell me about your current state of health?

_____

_____

_____

_____

My signature promises full payment for services as well as full disclosure of any and all health related illnesses and history as well as my full understanding that Energy Therapy is not a replacement for medical care from my healthcare provider.

Signature: _____ Date: _____